| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0000 | This visit was for the Investigation of Complaints IN00110609 and IN00111244. This visit resulted in a partially extended survey - immediate jeopardy.<br><br>Complaint IN00110609-Substantiated. Federal/state deficiency related to the allegation cited at F312.<br><br>Complaint IN00111244-Substantiated. Federal/state deficiency related to the allegation cited at F309.<br><br>Survey date: July 5, 2012<br>Extended survey date: July 6, 2012<br><br>Facility number: 000246<br>Provider number: 155355<br>AIM number: 100275420<br><br>Survey team:<br>Janet Adams, RN, TC<br>Shannon Pietrazewski, RN<br><br>Census bed type:<br>SNF/NF: 83<br>Total: 83<br><br>Census payor type:<br>Medicare: 6<br>Medicaid: 67 | F0000 | **The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.**<br>**Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after July 31, 2012.** | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Other: 10<br>Total: 83<br><br>Sample: 9<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed 7/11/12 by Jennie Bartelt, RN. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0309<br>SS=J | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>Based on record review and interview, the facility failed to ensure licensed staff initiated cardiopulmonary resuscitation (CPR) when the resident was found non-responsive and without pulse or respirations, and the resident expired. The deficient practice affected 1 of 3 residents reviewed related to potential need for CPR in a sample of 9 residents. (Resident #E)<br><br>The Immediate Jeopardy began on 6/26/12 when facility staff failed to initiate CPR for Resident #E who was found unresponsive and without a pulse. The facility Administrator and the Director of Nursing were notified of the immediate jeopardy on 7/5/12 at 5:00 p.m. The immediate jeopardy was removed, and the deficient practice corrected on 6/29/12, prior to the start of the survey and was therefore Past Noncompliance.<br><br>Findings include: | F0309 | Per 2567 Past noncompliance<br>No plan of correction required | 08/01/2012 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | The closed record for Resident #E was reviewed on 7/5/12 at 10:00 a.m. The resident was admitted to the facility on 7/27/2005. The resident's diagnoses included, but were not limited to, congestive heart failure, insulin dependent diabetes mellitus, peripheral vascular disease, high blood pressure, and a history of coronary artery disease.<br><br>The 6/26/12 Nursing Progress Notes indicated an entry was electronically made at 8:56 p.m. The entry was made by LPN#1. The entry indicated the CNA called the writer to Resident #E's room and the resident "was on the floor, non-responsive, no pulse/no HR (heart rate), CNA went to get RN, 911 was called, paramedics stated pt (patient) was deceased at 7:50 pm, family and MD are aware."<br><br>The admission Face Sheet indicated the resident's resuscitation status was listed as "Full Code". This indicated CPR was to be initiated if the resident was found without pulse or respirations.<br><br>An Observation note, completed on 6/22/12, and titled "Psychosocial/Social History Update" indicated the resident's Advanced Directive was for CPR to be initiated. The Observation note was made by Social Service staff. The note also | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | indicated there had been no change in the resident's cognition or ability to communicate and the resident had no language or hearing deficits.<br><br>The 6/2012 Physician Order Statement indicated there was a physician's order for "Full Code." This order was initially written on 12/20/08. A current care plan initiated on 10/12/11 indicated Resident #E chose to have life sustaining measures. The care plan interventions included for staff to honor the resident's choice and initiate CPR by trained persons.<br><br>Review of a list of the nursing employees who worked the evening shift on 6/26/12 was compared to a list of nursing staff with current CPR certification. There were six nursing staff members with current CPR certification working the evening shift on 6/26/12. The six staff members included RN #1 and LPN #1.<br><br>A First Aid CPR Nursing Skills Validation form was received from the Staff Development Nurse on 7/5/12 at 12:56 p.m. The form had an original date of 2/2010 and the date 7/2011 typed under the 2/2010 date. During interview at this time, the Staff Development Nurse indicated this was the current procedure staff was trained on. The form indicated | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | staff were to check for response or gently shake the victim, ask the victim if they are OK, tell someone to call 911 and get an AED (automatic defibrillator device), open airway and check for breathing 5-10 seconds by looking at chest, listening, and feeling, give 2 breaths with looking for chest to rise, check for carotid pulse 5-10 seconds, locate compression point, make sure victim is on his back and give 30 compressions 1 to 1 1/2 inches at a rate of 100 per minute, give 2 breaths, continue to do compressions/breathing cycles for 5 cycles and recheck for a pulse. The form also indicated once CPR is initiated it must be continued until EMS (Emergency Medical Services) arrives or physician is present and provides an order to discontinue.<br><br>When interviewed on 7/5/12 at 11:55 a.m., the DON (Director of Nursing) indicated Resident #E was a Full Code. The DON indicated that she was aware the CPR had not been initiated by any facility staff. The DON indicated she spoke with LPN#1 and the LPN indicated she was aware of Resident #E's code status and she did not initiate CPR because the resident had no pulse and no heart rate. The DON indicated 911 was called and when they arrived they began the appropriate measures including CPR. The DON indicated the paramedics | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | ceased CPR at the facility. The DON indicated it was close to end of the shift when she obtained interviews from staff and LPN#1 was placed on suspension then came into the facility the next day and placed a note under her door indicating she had resigned. The DON indicated the resident was a full code and CPR should have been initiated for Resident #E as that was his code status.<br><br>When interviewed on 7/5/12 at 12:06 p.m., the facility Administrator indicated she was informed of the above incident on the night it occurred. The Administrator indicated she was informed staff found the resident with no pulse and no respirations and 911 was called. The incident was reviewed further the next day and the Administrator indicated staff did not follow all the protocols for CPR. The Administrator indicated LPN #1 did have current CPR certification.<br><br>When interviewed on 7/5/12 at 12:08 p.m., the Director of Nursing indicated CNA #1 was off duty when she found the resident. The DON indicated she interviewed CNA #1 and CNA #1 indicated she went into the resident's room and found the resident on the floor and called out for the nurse who was in the hallway. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | When interviewed on 7/5/12 at 1:20 p.m., the DON indicated she interviewed RN #1 and RN #1 indicated the off duty CNA came upstairs and he came downstairs and assessed Resident #E. RN #1 indicated he assessed the resident and checked the vital signs. RN #1 indicated LPN #1 did not tell him Resident #E was a full code.<br><br>When interviewed on 7/5/12 at 4:05 p.m., the Director of Nursing indicated the First Aid CPR Nursing Skills Validation form is the guideline used for care of residents who are full code status.<br><br>The past noncompliance Immediate Jeopardy began on 6/26/12. The Immediate Jeopardy was removed and the deficient practice corrected by 6/29/12 after the facility implemented a systemic plan that included the following actions: The LPN who did not initiate CPR for the resident was suspended and did not return to work at the facility after 6/26/12. The RN who was called to the resident's room was educated by the DON on 6/26/12. The RN was inserviced on CPR procedures also on 6/27/12 before he was allowed to work that day. The facility initiated inservices on CPR and measures to be taken upon finding a resident without vital signs for all staff, including the contracted construction workers who | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | are completing renovations in the facility. The inservicing was completed for all staff except those on extended Family Medical Leave and those who work PRN on a rare basis. The facility implemented a system to more readily identify the Code Status of each resident. The name labels of resident who were to have CPR initiated were change to green and the chart labels for the other residents remained white. Green dots were placed on the room doors and green arm bands were placed on the residents who were to have CPR initiated. Interviews were completed with nursing and non-nursing staff members and the interviewed staff identified knowledge of the procedures they were inserviced on. Observations were made of green labels on charts, green dots on room name plates, and green wrist bands on residents. The facility also reviewed the CPR status of the employees to verify current CPR status of the employees.<br><br>This federal tag relates to Complaint IN00111244.<br><br>3.1-37(a) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F0312 SS=D | 483.25(a)(3)<br>ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>Based on observation, record review, and interview, the facility failed to provide a resident with timely incontinence care to maintain personal hygiene for 1 of 4 residents reviewed for incontinence care in the sample of 9. (Resident #F)<br><br>Findings include:<br><br>During initial tour on 7/5/12 at 9:20 a.m., Resident #F was observed in bed. LPN #3 asked the resident if she was wet and needed to be changed. The resident indicated she was wet. LPN #3 walked out of the room and spoke to CNA #2.<br><br>At the end of the tour on 7/5/12 at 9:45 a.m., LPN #3 asked the resident if she had been changed. The resident indicated she had not. LPN #3 checked the resident's brief and found a bath blanket folded inside the brief. The resident was interviewed at that time, and she indicated the bath blanket was used to "soak up the urine so it will not go through the brief."<br><br>On 7/5/12 at 11:20 a.m., CNA #2 and CNA #5 were observed using the Hoyer | F0312 | Resident #F was provided with incontinent care with no negative results of this outcome. A three day voiding diary will be completed to determine resident #F voiding patterns and a plan of care will be implemented specific for resident #F. The C.N.A. assignment sheet will be updated to address resident #F current voiding pattern.Current residents have the potential of being affected by this alleged deficiency. A facility audit will be conducted by the MDS Coordinator using the most recent MDS section H data. The identified resident's plan of care will be reviewed if any discrepancies or changes a three day voiding diary will be initiated. Upon completion, a plan of care will be revised as indicated. Any concerns or issues noted during the aduit related to incontence will be addressed immediately. All direct care staff is required to participate in an in-service related to following the plan or care July 31, 2012 facilitated by SDC and DNS. Skills validation for C.N.A.s will be conducted to ensure adequate incontinent care is provided.The alleged deficiency was evaluated relative to | 08/01/2012 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | lift to transfer the resident from her bed to her wheelchair. The staff was observed providing incontinence care prior to getting the resident out of bed.<br><br>On 7/5/12 at 3:15 p.m., the resident was observed sitting in her wheelchair watching television. During an interview with Resident #F at that time, she indicated the bath blanket observed earlier in the day was placed in her brief at 4:00 a.m. She indicated she was told by staff that someone came to her door around 8:00 a.m. to ask her if she needed anything, but she was asleep and did not remember the conversation. She indicated she had not been changed or cleaned between 4:00 a.m. and 11:20 a.m. or between 11:20 a.m. and 3:15 p.m. The resident lifted her top and pulled the waistband of her pants to show her brief was wet and bulky. The strips in the center of the brief had changed from yellow to green, indicating wetness. The resident stated, "I never get changed before dinner unless it is a shower, then I get left in bed, and they don't get me back up for dinner. It is too hard for the girls to get me up and down all the time."<br><br>On 7/6/12 at 9:20 a.m., the resident was observed in bed without a brief on, and three pads were under her buttocks. The resident indicated she was last changed | | systems, education and compliance. In-servicing for direct care staff will be conducted July 31, 2012 by SDC or designee on facility guidelines of following C.N.A. assignment sheet for incontinence plan of care. Skills validation for all C.N.A.s will be conducted July 31, 2012 to ensure adequate incontinent care is provided. Rounds by the charge nurse will be conducted daily on all shifts to ensure residents are provided timely incontinent care according to the care plan and C.N.A. assignment sheets and as needed.To ensure ongoing compliance with this corrective actionn the DNS/designee will be responsible for completion of audit tool titled, "Resident Care Rounds," no less than 5x per week for 3 weeks and then no less than 1x per month for 6 months. If threshold of 90% is not met an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | before breakfast and a bath blanket was not used during the night.<br><br>Resident #F's clinical record was reviewed on 7/05/12 at 10:45 a.m. Resident #F's diagnoses included, but were not limited to, paraparesis, acute osteomylitis, high blood pressure, and morbid obesity.<br><br>The June 2012 MAR (Medication Administration Record) indicated the resident received Lasix (a diuretic medication) 20 mg (milligrams) every day.<br><br>The 5/1/12 MDS (Minimum Data Set) quarterly assessment indicated the resident's cognition was intact, she received extensive assistance of two persons for personal hygiene and was always incontinent of bowel and bladder.<br><br>A care plan, initiated on 2/20/12, indicated, "Resident F is incontinent of urine & (and) bowel due to: unaware of urge to void (urinate) or defecate related to paraplegia. Interventions included, "...Check every 2 hours for incontinence...Provide incontinent care as needed."<br><br>This federal tag relates to Complaint IN00110609. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155355 | A. BUILDING 00<br>B. WING | 07/06/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WEST BEND NURSING AND REHABILITATION | 4600 W WASHINGTON AVE<br>SOUTH BEND, IN 46619 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3.1-38(a)(3)(A) | | | |